Direct Service Worker Duties

1. Provide any services indicated and needed as identified in the in the Family Plan for Change (CS-16B).

2. Discuss with all clients the importance of primary and preventive health care, including the impact of planning the spacing of children on the mother's and the family's health, prenatal care, well-baby and postnatal care, and sexually transmitted diseases (STDs). Timely referrals shall be made and assistance provided to access care. Barriers to accessing the services may include lack of transportation, lack of knowledge, inadequate or no insurance, lack of service providers, access to clinical services (i.e., inconvenient clinic hours), etc. If barriers to these primary health care services persist, they shall be discussed in supervisory conference, in order to identify ways to overcome the barriers.

   If no medical provider has been chosen by the family, the county health department may be a resource for them. Assistance may be provided in creating a linkage between the family and the health department or medical home, i.e., accompanying them on the first visit. Transportation services are available through some county health departments to assist in accessing needed health services.

3. Refer child to a Medicaid physician for an Early Periodic Screening and Diagnosis Test (EPSDT) physical examination with physician completion of an MS-40.

4. Plan with out-of-home care providers and other appropriate team members to ensure that all children in out-of-home care receive education on sexual development, appropriate to their age, life experiences, and living conditions. This information should include information on sexuality and venereal diseases.

5. Initiate, maintain and update case records and share copies as planned with the case manager county. Submit any reports requested by case manager county.

6. Assist child as needed with appropriate referrals for financial benefits or rehabilitation services.

7. Make presentations about case activity at PPRT/FST meeting and other staffings, such as the Child Protection Team meetings.

8. Obtain clearance, prepare authorizations, and monitor use of contractual and other treatment services, which have been initiated in the direct service county.

9. Notify case manager county of any major events occurring for the family or child, including need to obtain court approval for extraordinary medical care.

10. Provide transportation, as necessary, when appropriate to the case plan and when it has been determined another resource is not available.

11. Coordinate and monitor visits between parent(s) and child.

12. Complete and update SS-61, SS-63, CS-KIDS-2 and CS-EAS-1 as needed. Assist case manager county in completing and updating other forms necessary to the case plan, including CS-1 ATT and CS-3 for appropriate youth age 16 or over. Prepare and update CS-67 and CS-67A when appropriate.

13. For youth, age 13 through 15, who have not completed the "CHOICES" Independent Living Program, complete a "CHOICES" referral and submit to the ILP specialist. Participate in the assessment process with ILP specialist and contracted ILP trainer.

> Related Subject: Chapter 21, of this section, Chafee Foster Care Independent Living Program (CFCIP).

14. For youth, age 13 through 21, assist the case manager to assure the youth's participation in the development of their permanency plan and attendance at all Family Support Team/PPR meetings.

15. For youth, age 16 through 21, assist the case manager to complete necessary forms for referral to the Chafee Foster Care Independence Program (CFCIP).

> Related Subject: Chapter 2.3.2, of this section, Children's Service Worker Preparation for the Hearing.

> Related Subject: Chapter 7, of this section, Begin Work With the Family/Child(ren).

MEMORANDA HISTORY: